Residential Child Care Facility (RCCF) Billing Manual

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Residential Child Care Facility (RCCF) Program **1**

Program Overview **1**

Billing Information **1**
National Provider Identifier (NPI) 1
Paper Claims 1
Electronic Claims 1
Interactive Claim Submission and Processing 2
Batch Electronic Claim Submission 3
Testing and Vendor Certification 3

Program Benefits **4**
Enrollment and Participation 4
RCCF Benefits 4
RCCF Non-included Services: 6

CMS 1500 Paper Claim Reference Table **7**

Late Bill Override Date **16**

Residential Child Care Facility Claim Example **20**

Residential Child Care Facility (RCCF) Program

(Mental Health Program)

Program Overview

Providers must be enrolled as a Colorado Medical Assistance Program provider in order to:

- Treat a Colorado Medical Assistance Program member
- Submit claims for payment to the Colorado Medical Assistance Program

The Colorado Medical Assistance Program reimburses providers for medically necessary medical and surgical services furnished to eligible members.

Providers should refer to the Code of Colorado Regulations, Program Rules (10 CCR 2505-10), for specific information when providing medical/surgical services.

Billing Information

National Provider Identifier (NPI)

The Health Insurance Portability and Accountability Act (HIPAA) requires that covered entities (i.e., health plans, health care clearinghouses, and health care providers who transmit any health information electronically in connection with a transaction for which the Secretary of Health and Human Services has adopted a standard) use NPIs in standard transactions.

The Department of Health Care Policy and Financing (the Department) periodically modifies billing information. Therefore, the information in this manual is subject to change, and the manual is updated as new billing information is implemented.

Paper Claims

Electronic claims format shall be required unless hard copy claims submittals are specifically prior authorized by the Department. Requests for paper claim submission may be sent to the Department's fiscal agent, Xerox State Healthcare, P.O. Box 90, Denver, CO 80201-0090. The following claims can be submitted on paper and processed for payment:

- Claims from providers who consistently submit 5 claims or fewer per month (requires prior approval)
- Claims that, by policy, require attachments
- Reconsideration claims

Paper claims do not require an NPI, but do require the Colorado Medical Assistance Program provider number. Electronically mandated claims submitted on paper are processed, denied, and marked with the message "Electronic Filing Required".

Electronic Claims

Instructions for completing and submitting electronic claims are available through the following:

- X12N Technical Report 3 (TR3) for the 837P, 837I, or 837D (wpc-edi.com/)
- Companion Guides for the 837P, 837I, or 837D in the Provider Services Specifications section of the Department's Web site.

- Web Portal User Guide (via within the Web Portal)

The Colorado Medical Assistance Program collects electronic claim information interactively through the Colorado Medical Assistance Program Secure Web Portal (Web Portal) or via batch submission through a host system.

Interactive Claim Submission and Processing

Interactive claim submission through the Web Portal is a real-time exchange of information between the provider and the Colorado Medical Assistance Program. Colorado Medical Assistance Program providers may create and transmit HIPAA compliant 837P (Professional), 837I (Institutional), and 837D (Dental) claims electronically one at a time. These claims are transmitted through the Colorado Medical Assistance Program OnLine Transaction Processor (OLTP).

The OLTP reviews the claim information for compliance with Colorado Medical Assistance Program billing policy and returns a response to the provider's personal computer regarding that single transaction. If the claim is rejected, the OLTP sends a rejection response that identifies the rejection reason.

If the claim is accepted, the provider receives an acceptance message and the OLTP passes accepted claim information to the Colorado Medical Management Information System (MMIS) for final adjudication and reporting on the Colorado Medical Assistance Program Provider Claim Report (PCR).

The Web Portal contains online training, user guides, and help that describe claim completion requirements, a mechanism that allows the user to create and maintain a data base of frequently used information, edits that verify the format and validity of the entered information, and edits that assure that required fields are completed.

Because a claim submitter connects to the Web Portal through the Internet, there is no delay for "dialing up" when submitting claims. The Web Portal provides immediate feedback directly to the submitter. All claims are processed to provide a weekly Health Care Claim Payment/Advice (Accredited Standards Committee [ASC] X12N 835) transaction and/or PCR containing information related to submitted claims. The Web Portal provides access to the following reports through the File and Report Service (FRS):

- Accept/Reject Report
- Provider Claim Report
- Health Care Claim Payment/Advice (ASC X12N 835)
- Managed Care Reports such as Primary Care Physician Rosters
- Prior Authorization Letters

Users may also inquire about information generated from claims submitted via paper and through electronic data submission methods other than the Web Portal. Other inquiry options include:

- Eligibility Inquiry (interactive and batch)
- Claim Status Inquiry
- PAR Status Inquiry

Claims may be adjusted, edited and resubmitted, and voided in real time through the Web Portal. Access the Web Portal at Colorado Medical Assistance Program Secure Web Portal. For help with claim submission via the Web Portal, please choose the *User Guide* option available for each Web Portal transaction. For additional electronic billing information, please refer to the appropriate Companion Guide located in the Provider Services Specifications section.

Batch Electronic Claim Submission

Batch billing refers to the electronic creation and transmission of several claims in a group. Batch billing systems usually extract information from an automated accounting or patient billing system to create a group of claim transactions. Claims may be transmitted from the provider's office or sent through a billing vendor or clearinghouse.

All batch claim submission software must be tested and approved by the Colorado Medical Assistance Program fiscal agent.

Any entity sending electronic transactions through the fiscal agent's Electronic Data Interchange (EDI) Gateway for processing where reports and responses will be delivered must complete an EDI enrollment package. This provides EDI Gateway the information necessary to assign a Logon Name, Logon ID, and Trading Partner ID, which are required to submit electronic transactions, including claims.

An enrollment package may be obtained by contacting the Department's fiscal agent or by downloading it from the Provider Services EDI Support section.

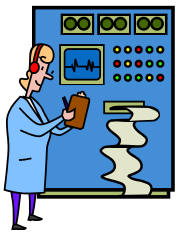
The X12N 837 Professional (837P), Institutional (837I), or Dental (837D) transaction data will be submitted to the EDI Gateway, which validates submission of American National Standards Institute (ANSI) X12N format(s). The TA1 Interchange Acknowledgement reports the syntactical analysis of the interchange header and trailer. If the data is corrupt or the trading partner relationship does not exist within the MMIS, the interchange will reject and a TA1 along with the data that will be forwarded to the State Healthcare Clearinghouse (SHCH) Technical Support for review and follow-up with the sender. An X12N 999 Functional Acknowledgement is generated when a file that has passed the header and trailer check passes through the SHCH.

If the file contains syntactical error(s), the segment(s) and element(s) where the error(s) occurred will be reported. After validation, the SHCH will then return the X12N 835 Remittance Advice containing information related to payees, payers, dollar amount, and payments. These X12N transactions will be returned to the Web Portal's FRS for retrieval by the trading partner, following the standard claims processing cycle.

Testing and Vendor Certification

Completion of the testing process must occur prior to submission of electronic batch claims to EDI Gateway. Assistance from EDI business analysts is available throughout this process. Each test transmission is inspected thoroughly to ensure no formatting errors are present. Testing is conducted to verify the integrity of the format, not the integrity of the data; however, in order to simulate a production environment, EDI requests that providers send real transmission data.

The number of required test transmissions depends on the number of format errors on a transmission and the relative severity of these errors. Additional testing may be required in the future to verify any changes made to the MMIS have not affected provider submissions. Also, changes to the ANSI formats may require additional testing.



In order to expedite testing, EDI Gateway requires providers to submit all X12N test transactions to Edifecs prior to submitting them to EDI Gateway. The EDIFECS service is free to providers to certify X12N readiness. EDIFECS offers submission and rapid result turnaround 24 hours a day, 7 days a week. For more information, go to edifecs.com.

Program Benefits

Colorado Medical Assistance Program mental health benefits are provided through Residential Child Care Facilities (RCCFs) to enrolled members who reside in the facility on a fee-for-service basis.

Enrollment and Participation

Almost all Colorado Medical Assistance Program members are enrolled in the Mental Health Programs. However, members residing in Residential Child Care Facilities can receive mental health services from physicians, licensed mental health professionals, nurse practitioners, and physician assistants. RCCFs enroll and act as billing agents by submitting claims for these provider types either employed or contracted with the RCCF.

RCCF Benefits

RCCFs are responsible for providing mental health services to members residing in their facilities.

The following procedure codes can be billed for services provided in a RCCF by a physician, osteopath, licensed psychologist, licensed clinical social worker, licensed marriage, and family therapist or licensed professional counselor:

Code	Description	Prior Authorization
90791 or 90792	Psychiatric diagnostic evaluation or Psychiatric diagnostic evaluation with med services (1 unit per day)	
+90785	Interactive Complexity is an add-on-code for interactive complexity to be reported in conjunction with codes for diagnostic psychiatric evaluation, psychotherapy, psychotherapy when preformed with an evaluation and management service and group psychotherapy. Interactive complexity refers to a specific communization factors that complicate the delivery of a psychiatric procedure.	
90832	Individual psychotherapy, 30 minutes face to face with patient and/or family (2 units per day of 90832 or +90833)	
90834	Individual psychotherapy, 45 minutes face to face services with patient and/or family member (2 units of 90834, 90837or +90836 per day)	
90837	Individual psychotherapy, 60 minutes face to face services with patient and/or family member (2 units of 90834, 90837 or +90836 per day)	
90846	Family psychotherapy (without the patient present)(family psychotherapy can only be billed 1 unit per date of service, 90846 or 90847)	
90847	Family therapy (conjoint therapy) (with patient present unless contact with family members is contraindicated.) (family psychotherapy can only be billed 1 unit per date of service, 90846 or 90847)	

Code	Description	Prior Authorization
90853	Group psychotherapy (other than of a multifamily group) (15 minute units, up to 8 units per date of service)	
96101	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and prepar ing the report professional. (Benefits are available for face-to-face patient services only. Do not bill for time spent interpreting test results and preparing the report.) (only 1 unit of professional psychological testing per date of service)	
96102	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI and WAIS), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face (Benefits are available for face-to-face patient services only. Do not bill for time spent interpreting test results and preparing the report.) (1 unit of technician psychological testing per date of service)	

The following procedure codes can be billed for services provided in a RCCF by a physician or osteopath:

Code	Description	Prior Authorization
+90833	Psychotherapy, 30 minutes with patient and/or family member when preformed with an evaluation and management service. (2 units per day of 90832 or +90833)	
+90836	Psychotherapy, 45 minutes with patient and/or family member when preformed with an evaluation and management service. (2 units of 90834, 90837 or +90836 per day)	
90839	Psychotherapy for crisis first 60 minutes (1 unit per day, when billing for psychotherapy for crisis, no other services may be billed on that date of service)	
+90840	Psychotherapy for crisis, each additional 30 minutes. (2 unit per day, to be billed with 90839, when billing for psychotherapy for crisis, no other services may be billed on that date of service)	

The following procedure code can be billed for services provided in a RCCF by a physician, osteopath, nurse practitioner or physician assistant:

Code	Description	Prior Authorization
+90863	Pharmacologic management, including prescription and review of medication, when preformed with a psychotherapy service. (1 hour per date of service)	

RCCF Non-included Services:

- Mental health-related prescription drugs. Claims for prescription drugs are submitted to the Colorado Medical Assistance Program fiscal agent under the FFS Reimbursement Program or to the MCO for MCO-enrolled members.
- Services in a Psychiatric Residential Treatments Facility (PRTF). PRTF claims are submitted to the fiscal agent for a per diem reimbursement.

CMS 1500 Paper Claim Reference Table

The paper claim reference table lists required and conditional fields for the CMS 1500 paper claim form for RCCF claims. For complete CMS 1500 paper claim instructions, please refer to the Medicaid Provider Information manual located on the Department's website (Colorado.gov/hcpf) → For Our Providers → Provider Services → Billing Manuals.

The appropriate POS codes for RCCF paper and electronic claim submissions services are 11 (Office) or 14 (Group Home) and are identified by using the specific modifiers along with the procedure codes (see above table).

Instructions for completing and submitting electronic claims are available through the X12N Technical Report 3 (TR3) for the 837P (wpc-edi.com), 837P Companion Guide (in the Provider Services Specifications section of the Department's Web site), and in the Web Portal User Guide (via within the portal).

CMS Field #	Field Label	Field is?	Instructions
1	**Insurance Type**	Required	Place an "X" in the box marked as Medicaid.
1a	**Insured's ID Number**	Required	Enter the member's Colorado Medical Assistance Program seven-digit Medicaid ID number as it appears on the Medicaid Identification card. Example: A123456.
2	**Patient's Name**	Required	Enter the member's last name, first name, and middle initial.
3	**Patient's Date of Birth / Sex**	Required	Enter the patient's birth date using two digits for the month, two digits for the date, and two digits for the year. Example: 070114 for July 1, 2014. Place an "X" in the appropriate box to indicate the sex of the member.
4	**Insured's Name**	Not Required	
5	**Patient's Address**	Not Required	
6	**Patient's Relationship to Insured**	Not Required	

CMS Field #	Field Label	Field is?	Instructions
7	**Insured's Address**	Not Required	
8	**Reserved for NUCC Use**		
9	**Other Insured's Name**	Not Required	
9a	**Other Insured's Policy or Group Number**	Not Required	
9b	**Reserved for NUCC Use**		
9c	**Reserved for NUCC Use**		
9d	**Insurance Plan or Program Name**	Not Required	
10a-c	**Is Patient's Condition Related to?**	Conditional	When appropriate, place an "X" in the correct box to indicate whether one or more of the services described in field 24 are for a condition or injury that occurred on the job, as a result of an auto accident or other.
10d	**Reserved for Local Use**		
11	**Insured's Policy, Group or FECA Number**	Not Required	
11a	**Insured's Date of Birth, Sex**	Not Required	
11b	**Other Claim ID**	Not Required	

CMS Field #	Field Label	Field is?	Instructions
11c	**Insurance Plan Name or Program Name**	Not Required	
11d	**Is there another Health Benefit Plan?**	Not Required	
12	**Patient's or Authorized Person's signature**	Required	Enter "Signature on File", "SOF", or legal signature. If there is no signature on file, leave blank or enter "No Signature on File". Enter the date the claim form was signed.
13	**Insured's or Authorized Person's Signature**	Not Required	
14	**Date of Current Illness Injury or Pregnancy**	Not Required	
15	**Other Date**	Not Required	
16	**Date Patient Unable to Work in Current Occupation**	Not Required	
17	**Name of Referring Physician**	Not Required	
18	**Hospitalization Dates Related to Current Service**	Not Required	
19	**Additional Claim Information**	Conditional	**LBOD** Use to document the Late Bill Override Date for timely filing.
20	**Outside Lab?** **$ Charges**	Not Required	

CMS Field #	Field Label	Field is?	Instructions
21	**Diagnosis or Nature of Illness or Injury**	Required	Enter at least one but no more than twelve diagnosis codes based on the member's diagnosis/condition. Enter applicable ICD indicator to identify which version of ICD codes is being reported. 0 ICD-10-CM (DOS 10/1/15 and after) 9 ICD-9-CM (DOS 9/30/15 and before)
22	**Medicaid Resubmission Code**	Conditional	List the original reference number for resubmitted claims. When resubmitting a claim, enter the appropriate bill frequency code in the left-hand side of the field. 7 Replacement of prior claim 8 Void/Cancel of prior claim This field is not intended for use for original claim submissions.
23	**Prior Authorization**	Not Required	
24	**Claim Line Detail**	Information	The paper claim form allows entry of up to six detailed billing lines. Fields 24A through 24J apply to each billed line. **Do not enter more than six lines of information** on the paper claim. If more than six lines of information are entered, the additional lines will not be entered for processing. Each claim form must be fully completed (totaled). **Do not file continuation claims** (e.g., Page 1 of 2).
24A	**Dates of Service**	Required	The field accommodates the entry of two (2) dates: a "From" date of services and a "To" date of service. Enter the date of service using two (2) digits for the month, two (2) digits for the date and two (2) digits for the year. Example: 010114 for January 1, 2014 From To **01 01 15** | | | | | | Or

CMS Field #	Field Label	Field is?	Instructions
			From To **01 01 15 01 01 15** Span dates of service From To **01 01 15 01 31 15** Practitioner claims must be consecutive days. Single Date of Service: Enter the six digit date of service in the "From" field. Completion of the "To field is not required. Do not spread the date entry across the two fields. Span billing: Permissible if the same service (same procedure code) is provided on consecutive dates. **Supplemental Qualifier** To enter supplemental information, begin at 24A by entering the qualifier and then the information. ZZ Narrative description of unspecified code N4 National Drug Codes VP Vendor Product Number OZ Product Number CTR Contract Rate JP Universal/National Tooth Designation JO Dentistry Designation System for Tooth & Areas of Oral Cavity
24B	**Place of Service**	Required	Enter the Place of Service (POS) code that describes the location where services were rendered. The Colorado Medical Assistance Program accepts the CMS place of service codes. 11 Office 14 Group Home
24C	**EMG**	Not Required	

CMS Field #	Field Label	Field is?	Instructions
24D	**Procedures, Services, or Supplies**	Required	Enter the HCPCS procedure code that specifically describes the service for which payment is requested. All procedures must be identified with codes in the current edition of Physicians Current Procedural Terminology (CPT). CPT is updated annually. HCPCS Level II Codes The current Medicare coding publication (for Medicare crossover claims only). Only approved codes from the current CPT or HCPCS publications will be accepted.
24D	**Modifier**	Conditional	Enter the appropriate procedure-related modifier that applies to the billed service. Up to four modifiers may be entered when using the paper claim form. EP **Part of EPSDT Program**
24E	**Diagnosis Pointer**	Required	Enter the diagnosis code reference letter (A-L) that relates the date of service and the procedures performed to the primary diagnosis. At least one diagnosis code reference letter must be entered. When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow. This field allows for the entry of 4 characters in the unshaded area.
24F	**$ Charges**	Required	Enter the usual and customary charge for the service represented by the procedure code on the detail line. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number. Some CPT procedure codes are grouped with other related CPT procedure codes. When more than one procedure from the same group is billed, special multiple pricing rules apply. The base procedure is the procedure with the highest allowable amount. The base code is used to determine the allowable amounts for additional CPT surgical

CMS Field #	Field Label	Field is?	Instructions
			procedures when more than one procedure from the same grouping is performed. Submitted charges cannot be more than charges made to non-Colorado Medical Assistance Program covered individuals for the same service. Do not deduct Colorado Medical Assistance Program co-payment or commercial insurance payments from the usual and customary charges.
24G	**Days or Units**	Required	Enter the number of services provided for each procedure code. Enter whole numbers only- do not enter fractions or decimals.
24G	**Days or Units**	General Instructions	A unit represents the number of times the described procedure or service was rendered. Except as instructed in this manual or in Colorado Medical Assistance Program bulletins, the billed unit must correspond to procedure code descriptions. The following examples show the relationship between the procedure description and the entry of units.
24H	**EPSDT/Family Plan**	Conditional	**EPSDT** (shaded area) For Early & Periodic Screening, Diagnosis, and Treatment related services, enter the response in the shaded portion of the field as follows: AV Available- Not Used S2 Under Treatment ST New Service Requested NU Not Used **Family Planning** (unshaded area) Not Required
24I	**ID Qualifier**	Not Required	
24J	**Rendering Provider ID #**	Required	In the shaded portion of the field, enter the eight-digit Colorado Medical Assistance Program provider number assigned to the individual who actually performed or

CMS Field #	Field Label	Field is?	Instructions
			rendered the billed service. This number cannot be assigned to a group or clinic. NOTE: When billing a paper claim form, do not use the individual's NPI.
25	**Federal Tax ID Number**	Not Required	
26	**Patient's Account Number**	Optional	Enter information that identifies the patient or claim in the provider's billing system. Submitted information appears on the Provider Claim Report (PCR).
27	**Accept Assignment?**	Required	The accept assignment indicates that the provider agrees to accept assignment under the terms of the payer's program.
28	**Total Charge**	Required	Enter the sum of all charges listed in field 24F. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number.
29	**Amount Paid**	Not Required	
30	**Rsvd for NUCC Use**		
31	**Signature of Physician or Supplier Including Degrees or Credentials**	Required	Each claim must bear the signature of the enrolled provider or the signature of a registered authorized agent. A holographic signature stamp may be used if authorization for the stamp is on file with the fiscal agent. An authorized agent or representative may sign the claim for the enrolled provider if the name and signature of the agent is on file with the fiscal agent. Each claim must have the date the enrolled provider or registered authorized agent signed the claim form. Enter the date the claim was signed using two digits for the month, two digits for the date and two digits for the year. Example: 070114 for July 1, 2014. **Unacceptable signature alternatives:**

CMS Field #	Field Label	Field is?	Instructions
			Claim preparation personnel may not sign the enrolled provider's name. Initials are not acceptable as a signature. Typed or computer printed names are not acceptable as a signature. "Signature on file" notation is not acceptable in place of an authorized signature.
32	**32- Service Facility Location Information** **32a- NPI Number** **32b- Other ID #**	Not Required	
33	**33- Billing Provider Info & Ph. #** **33a- NPI Number** **33b- Other ID #**	Required	Enter the name of the individual or organization that will receive payment for the billed services in the following format: 1st Line Name 2nd Line Address 3rd Line City, State and ZIP Code 33a- NPI Number Enter the NPI of the billing provider 33b- Other ID # Enter the eight-digit Colorado Medical Assistance Program provider number of the individual or organization.

Late Bill Override Date

For electronic claims, a delay reason code must be selected, and a date must be noted in the "Claim Notes/LBOD" field.

Valid Delay Reason Codes

1 Proof of Eligibility Unknown or Unavailable

3 Authorization Delays

7 Third Party Processing Delay

8 Delay in Eligibility Determination

9 Original Claim Rejected or Denied Due to a Reason Unrelated to the Billing Limitation Rules

11 Other

The Late Bill Override Date (LBOD) allows providers to document compliance with timely filing requirements when the initial timely filing period has expired. Colorado Medical Assistance Program providers have 120 days from the date of service to submit their claim. For information on the 60-day resubmission rule for denied/rejected claims, please see the General Provider Information manual in the Provider Services Billing Manuals section of the Department's Web site.

Making false statements about timely filing compliance is a misrepresentation and falsification that, upon conviction, makes the individual who prepares the claim and the enrolled provider subject to a fine and imprisonment under state and/or federal law.

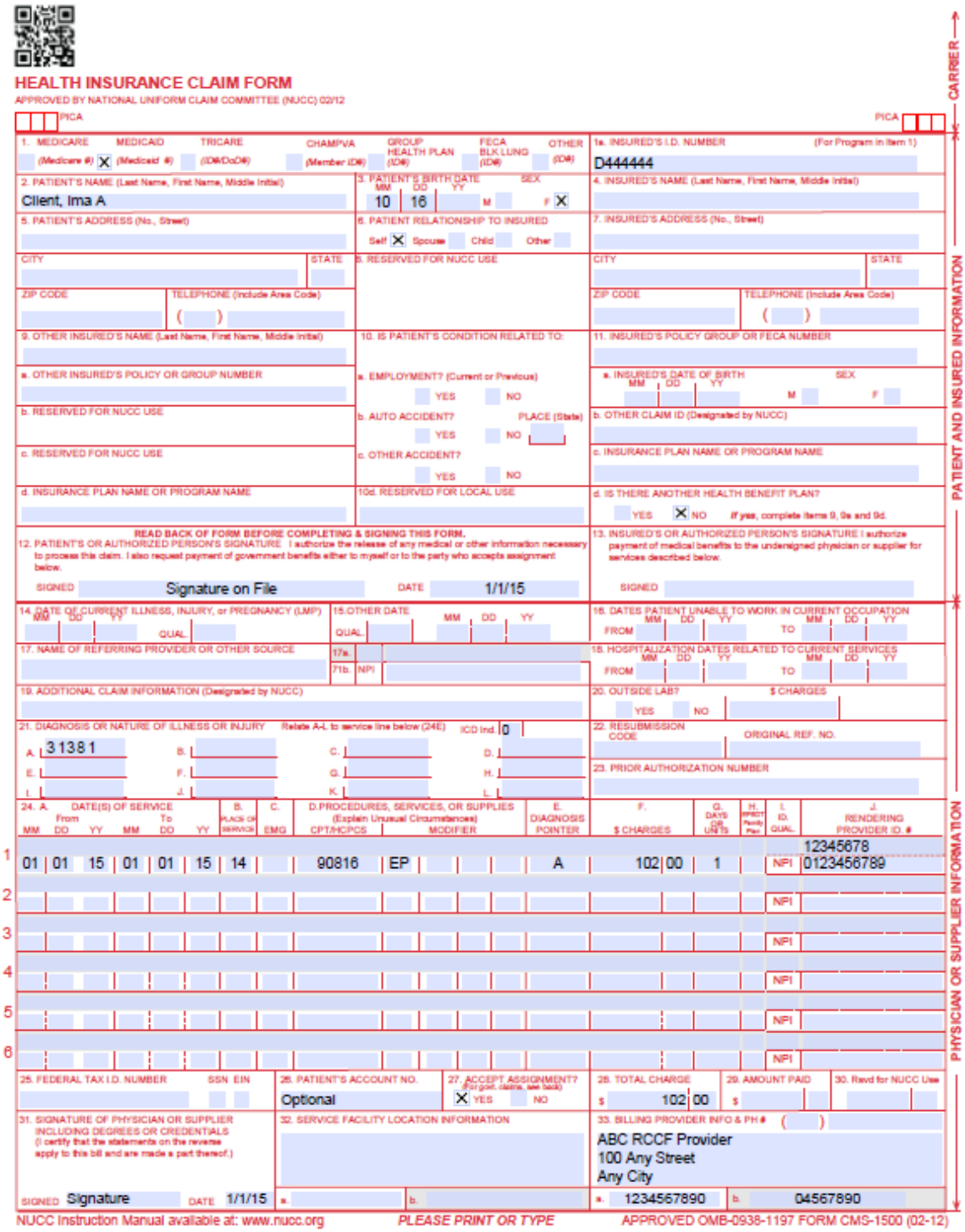
Billing Instruction Detail	Instructions
LBOD Completion Requirements	• Electronic claim formats provide specific fields for documenting the LBOD. • Supporting documentation must be kept on file for 6 years. • For paper claims, follow the instructions appropriate for the claim form you are using. ➢ *UB-04*: Occurrence code 53 and the date are required in FL 31-34. ➢ *CMS 1500*: Indicate "LBOD" and the date in box 19 – Additional Claim Information. ➢ *2006 ADA Dental*: Indicate "LBOD" and the date in box 35 - Remarks
Adjusting Paid Claims	If the initial timely filing period has expired and a previously submitted claim that was filed within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was paid and now needs to be adjusted, resulting in additional payment to the provider. **Adjust the claim within 60 days** of the claim payment. Retain all documents that prove compliance with timely filing requirements. *Note: There is no time limit for providers to adjust paid claims that would result in repayment to the Colorado Medical Assistance Program.*

Billing Instruction Detail	Instructions
	LBOD = the run date of the Colorado Medical Assistance Program Provider Claim Report showing the payment.
Denied Paper Claims	If the initial timely filing period has expired and a previously submitted paper claim that was filed within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was denied. **Correct the claim errors and refile within 60 days** of the claim denial or rejection. Retain all documents that prove compliance with timely filing requirements. **LBOD** = the run date of the Colorado Medical Assistance Program Provider Claim Report showing the denial.
Returned Paper Claims	A previously submitted paper claim that was filed within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was returned for additional information. **Correct the claim errors and re-file within 60 days** of the date stamped on the returned claim. Retain a copy of the returned claim that shows the receipt or return date stamped by the fiscal agent. **LBOD** = the stamped fiscal agent date on the returned claim.
Rejected Electronic Claims	An electronic claim that was previously entered within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was rejected and information needed to submit the claim was not available to refile at the time of the rejection. **Correct claim errors and refile within 60 days** of the rejection. Maintain a printed copy of the rejection notice that identifies the claim and date of rejection. **LBOD** = the date shown on the claim rejection report.
Denied/Rejected Due to Member Eligibility	An electronic eligibility verification response processed during the original Colorado Medical Assistance Program timely filing period states that the individual was not eligible but you were subsequently able to verify eligibility. Read also instructions for retroactive eligibility. **File the claim within 60 days** of the date of the rejected eligibility verification response. Retain a printed copy of the rejection notice that identifies the member and date of eligibility rejection. **LBOD** = the date shown on the eligibility rejection report.
Retroactive Member Eligibility	The claim is for services provided to an individual whose Colorado Medical Assistance Program eligibility was backdated or made retroactive. File the claim within 120 days of the date that the individual's eligibility information appeared on state eligibility files. Obtain and maintain a letter or form from the county departments of social services that: • Identifies the patient by name

Billing Instruction Detail	Instructions
	• States that eligibility was backdated or retroactive • Identifies the date that eligibility was added to the state eligibility system. **LBOD** = the date shown on the county letter that eligibility was added to or first appeared on the state eligibility system.
Delayed Notification of Eligibility	The provider was unable to determine that the patient had Colorado Medical Assistance Program coverage until after the timely filing period expired. **File the claim within 60 days** of the date of notification that the individual had Colorado Medical Assistance Program coverage. Retain correspondence, phone logs, or a signed Delayed Eligibility Certification form (see Certification & Request for Timely Filing Extension in the Provider Services Forms section) that identifies the member, indicates the effort made to identify eligibility, and shows the date of eligibility notification. • Claims must be filed within 365 days of the date of service. No exceptions are allowed. • This extension is available only if the provider had no way of knowing that the individual had Colorado Medical Assistance Program coverage. • Providers who render services in a hospital or nursing facility are expected to get benefit coverage information from the institution. • The extension does not give additional time to obtain Colorado Medical Assistance Program billing information. • If the provider has previously submitted claims for the member, it is improper to claim that eligibility notification was delayed. **LBOD** = the date the provider was advised the individual had Colorado Medical Assistance Program benefits.
Electronic Medicare Crossover Claims	An electronic claim is being submitted for Medicare crossover benefits within 120 days of the date of Medicare processing/ payment. (Note: On the paper claim form (only), the Medicare SPR/ERA date field documents crossover timely filing and completion of the LBOD is not required.) **File the claim within 120 days** of the Medicare processing/ payment date shown on the SPR/ERA. Maintain the original SPR/ERA on file. **LBOD** = the Medicare processing date shown on the SPR/ERA.
Medicare Denied Services	The claim is for Medicare denied services (Medicare non-benefit services, benefits exhausted services, or the member does not have Medicare coverage) being submitted within 60 days of the date of Medicare processing/denial. *Note: This becomes a regular Colorado Medical Assistance Program claim, not a Medicare crossover claim.*

Billing Instruction Detail	Instructions
	File the claim within 60 days of the Medicare processing date shown on the SPR/ERA. Attach a copy of the SPR/ERA if submitting a paper claim and maintain the original SPR/ERA on file. **LBOD** = the Medicare processing date shown on the SPR/ERA.
Commercial Insurance Processing	The claim has been paid or denied by commercial insurance. **File the claim within 60 days** of the insurance payment or denial. Retain the commercial insurance payment or denial notice that identifies the patient, rendered services, and shows the payment or denial date. Claims must be filed within 365 days of the date of service. No exceptions are allowed. If the claim is nearing the 365-day limit and the commercial insurance company has not completed processing, file the claim, receive a denial or rejection, and continue filing in compliance with the 60-day rule until insurance processing information is available. **LBOD** = the date commercial insurance paid or denied.
Correspondence LBOD Authorization	The claim is being submitted in accordance with instructions (authorization) from the Colorado Medical Assistance Program for a 60 day filing extension for a specific member, claim, services, or circumstances. **File the claim within 60 days** of the date on the authorization letter. Retain the authorization letter. **LBOD** = the date on the authorization letter.
Member Changes Providers during Obstetrical Care	The claim is for obstetrical care where the patient transferred to another provider for continuation of OB care. The prenatal visits must be billed using individual visit codes but the service dates are outside the initial timely filing period. **File the claim within 60 days** of the last OB visit. Maintain information in the medical record showing the date of the last prenatal visit and a notation that the patient transferred to another provider for continuation of OB care. **LBOD** = the last date of OB care by the billing provider.

Residential Child Care Facility Claim Example



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare #) X | MEDICAID (Medicaid #) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): D444444

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Client, Ima A

3. PATIENT'S BIRTH DATE MM DD YY: 10 16 | SEX M | F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self X | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M | F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES | NO | PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | X NO — If yes, complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: Signature on File DATE: 1/1/15

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY | QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES | NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. 31381 B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01 01 15 | 01 01 15	14		90816	EP		A	102 00	1		NPI 12345678 0123456789
2											NPI
3											NPI
4											NPI
5											NPI
6											NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: Optional

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES | NO

28. TOTAL CHARGE $ 102 00

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED Signature DATE 1/1/15

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

ABC RCCF Provider
100 Any Street
Any City

a. 1234567890 b. 04567890

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM CMS-1500 (02-12)

Residential Child Care facility Revision Log

Revision Date	Section/Action	Pages	Made by
07/08/2011	*Drafted Manual*	*All*	*dc*
07/11/2011	*Accepted changes and verified TOC*	*Throughout*	*jg*
08/10/2010	*Formatted* *Updated TOC*	*All* *1*	*jg*
12/06/2011	*Replaced 997 with 999* *Replaced wpc-edi.com/hipaa with wpc-edi.com/* *Replaced Implementation Guide with Technical Report 3 (TR3)*	*4* *2* *2*	*ss*
10/2012	*Removed Therapeutic from the program name* *Updated Billing Information*	*All* *2-5*	*cc*
04/13/2013	*Updated TOC* *Reformatted*	*I* *Throughout*	*jg*
05/22/2014	*Removed references to the Primary Care Physician Program*	*8*	*Mm*
8/8/14	*Replaced all CO 1500 references with CMS 1500*	*Throughout*	*ZS*
8/8/14	*Updated Professional Claim Billing Instructions section with CMS 1500 information.*		*ZS*
8/1/14	*Changed all references from client to member*	*Throughout*	*ZS*
8/11/14	*Updated all web links to reflect new Department website*	*Throughout*	*MM*
11/04/14	*Accepted changes and verified TOC*	*Throughout*	*mc*
11/04/14	*Removed "pacific" from Department website hyperlinks*	*Throughout*	*mc*
11/04/14	*Corrected link that directs to Web Portal, used to direct to the Department web site.*	*2*	*mc*
12/08/14	*Removed Appendix H information, added Timely Filing document information*	*17*	*mc*
04/28/2015	*Changed the word unshaded to shaded*	*24J*	*Bl*
8/20/2015	*Added Allowed Procedure Codes table template*	*2*	*CF*
9/1/15	*Removed mention of ICD-9* *Reviewed for mention of ColoradoPAR or CWQI but none.* *Added Prior Authorization column to procedure code table* *Changed PRTF claims are submitted to the FA for a per diem reimbursement (not FFS)*	*11* *Throughout* *4-6* *7*	*JH*
09/08/2015	*Updated TOC, accepted changes, and removed blank page*	*Throughout*	*bl*